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Issue Date: 30 April 2004

Case No.: 2001-BLA-00398
2001-BLA-00399

In the Matter of

MAE ANN SHARPE, w/o and o/b/o
WILLIAM A. SHARPE
Claimant

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

John A. Bednarz, Jr., Esquire
For Claimant

Ashley M. Harman, Esquire
For Director

Before: ROBERT D. KAPLAN
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS UPON REMAND

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was

[1] The regulations cited are the pre-amendment regulations. 20 C.F.R. § 718, et. seq. (2000).

due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

This case is before me upon remand from the Benefits Review Board ("the Board"). In a July 23, 2002 Decision and Order, I denied Employer's request for modification of the living miner's claim and awarded survivor's benefits to Claimant. Subsequently, Employer appealed my decision to the Board. In an August 22, 2003 Decision and Order, the Board affirmed the decision in part and vacated the decision in part. The Board remanded this case and ordered that I reconsider whether the previously submitted evidence, in conjunction with the newly submitted evidence, establishes that Administrative Law Judge Julius Johnson erred in finding the existence of complicated pneumoconiosis. The Board also ordered that I reconsider whether the chest X-ray evidence is sufficient to establish the existence of complicated pneumoconiosis pursuant to § 718.304(a). Finally, I must reconsider the medical opinion of Dr. Castle and also reconsider the CT scan medical evidence of record.

On December 18, 2003 Employer submitted a brief outlining its arguments on remand. Claimant filed a brief on March 29, 2004. The following decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The parties stipulated that the miner established a coal mine employment history totaling 39 years. (T 19 – 20)[2] The issues presented on remand are:

1. whether the miner had complicated pneumoconiosis;

2. whether the miner had simple pneumoconiosis;

3. whether the miner's pneumoconiosis arose out of coal mine employment;

4. whether the miner was totally disabled;

5. whether the miner's total disability was due to pneumoconiosis;

6. whether the miner's death was due to pneumoconiosis;

7. whether there was a mistake in a determination of fact pursuant to § 725.310.

[2] The following abbreviations are used herein: "CX" refers to Claimant's exhibits; "DX" refers to Director's exhibits, "EX" refers to Employer's exhibits; and "T" refers to the transcript of the September 4, 2001 hearing.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

William A. Sharpe ("the miner") filed a claim for living miner's benefits on March 2, 1989. (DX 1) On May 14, 1991, Administrative Law Judge Giles J. McCarthy denied benefits. Subsequently, the Board remanded the case and Judge Julius Johnson awarded benefits on August 26, 1993. The Board affirmed this decision on September 28, 1994. The miner died on April 18, 2000 and Claimant filed a survivor's claim for benefits on April 26, 2000. In a May 5, 2000 Proposed Decision and Order, the District Director awarded benefits to Claimant. On June 15, 2000, within one year of the cessation of living miner's benefits, Employer requested modification of the living miner's benefits award. Subsequently, a formal hearing was held before me. On July 23, 2002,I issued a Decision and Order awarding survivor's benefits and denying Employer's request for modification of the living miner's benefits award. On August 22, 2003, the Board vacated the benefits award and remanded this matter to me for additional consideration.

B. Factual Background

Claimant married the miner on October 1, 1960 and was married to him at the time of his death on April 18, 2000. (DX 8; T 16) Claimant testified that the miner was treated by Dr. Richard Elliot and Dr. Kapadia, and not by Dr. Maloney, the physician who signed the death certificate. (T 17 – 18) Claimant testified that her husband's last coal mine employment took place in Virginia.[3]

C. Entitlement

Pursuant to § 725.310, any party, before one year from the date of the last payment of benefits or before one year after the denial of benefits, may request modification if the evidence establishes at least one of the following: (1) a mistake in a determination of fact, or (2) by current evidence, a change in conditions. § 725.310(a).

As this is a request for modification, the instant claim must be denied unless the additional evidence demonstrates that one of the applicable conditions of entitlement has changed since the denial of the prior claim or if the evidence of record demonstrates a mistake in a determination of fact. § 725.310(c).

With regard to change in conditions of entitlement, Nataloni v. Director, OWCP, 17 B.L.R. 1-82, 84 (1993), states:

> In determining whether claimant has established a change in conditions, the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence,

[3] As the miner's coal mine employment took place in Virginia, this case arises in the jurisdiction of the Fourth Circuit Court of Appeals.

> considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish the element or elements of entitlement which defeated entitlement in the prior decision.

With regard to mistake in a determination of fact, Nataloni states:

> [U]nlike [the consideration of] a change in condition, the administrative law judge is bound to consider the entirety of the evidentiary record, and not merely the newly submitted evidence, in making a determination of a mistake in fact upon modification.

Id.

The Fourth Circuit has held that modification vests a fact finder with "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." Jessee v. Director, OWCP, 5 F.3d 723, 724 (1993) citing O'Keefe v. Aerojet-General Shipyards, Inc., 404 U.S. 254, 256 (1971) (per curiam). Thus, there is "no need for a smoking-gun factual error, changed circumstances, or startling new evidence." Jessee, 5 F.3d at 725.

MODIFICATION OF THE 1993 LIVING MINER'S CLAIM

A. The Prior Record Evidence

At the outset, Employer asserts that Judge Johnson erred in finding that the medical evidence of record established complicated pneumoconiosis, pursuant to § 718.304(a). (Employer's brief, p. 4) Therefore, I shall first review the August 26, 1993 living miner's claim to determine if there was a mistake in a determination of fact.

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

(1) X-ray evidence. § 718.202(a)(1).

(2) Biopsy or autopsy evidence. § 718.202(a)(2).

(3) Regulatory presumptions. § 718.202(a)(3).

a) § 718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of

coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

(4) Physician's opinions based upon objective medical evidence § 718.202(a)(4).

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102.[4]

In finding that the miner had complicated pneumoconiosis, Judge Johnson first reviewed the 22 interpretations by B-readers of the four chest X-ray examinations performed on September 25, 1974, April 3, 1989, July 27, 1989, and August 8, 1990. (DX 56) Judge Johnson also considered the physicians' corresponding medical opinions. Section § 718.202(a)(4) states:

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201 (a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment

[4]A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

> significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

Judge Johnson gave greater weight to the positive interpretations of Dr. Navani, Dr. Aycoth, and Dr. Capiello, each of whom diagnosed the presence of complicated pneumoconiosis (category "A" or "B") pursuant to § 718.304(a). Judge Johnson gave less weight to the interpretations of Dr. Templeton, Dr. Wheeler, Dr. Dahhan, Dr. Fino, and Dr. Scott, each of whom, according to Judge Johnson, considered the abnormality in the miner's lungs to be evidence of healed tuberculosis, cancer, simple pneumoconiosis, histoplasmosis, or a combination of these diseases.

As support for his decision to give less weight to these medical opinions, Judge Johnson noted that there was "substantial agreement among the various readings that there is an abnormality in the upper zones of Claimant's lungs." (DX 56, p. 5) Judge Johnson stated:

> It is more reasonable and logical to characterize the lesions as pneumoconiosis – in view of the admitted presence of some degree of the diseases in Claimant's lungs – than to speculate about alternative disease processes for which there is absolutely no clinical or historical support.

(DX 56, p. 6) Accordingly, Judge Johnson credited the physicians who determined that the miner had complicated pneumoconiosis over the physicians who concluded otherwise.

I note that Judge Johnson mischaracterized Dr. Fino's medical opinion.[5] Judge Johnson stated that Dr. Fino observed lesions on the chest X-rays which were caused by tuberculosis or histoplasmosis. (DX 56, p. 5) However, a review of Dr. Fino's December 28, 1990 deposition, shows that Dr. Fino opined that the miner had simple pneumoconiosis, but *not* tuberculosis or histoplasmosis. In response to a question about how physicians should interpret large opacities on a chest X-ray, Dr. Fino stated that, "in the proper clinical setting if indeed there is an abnormality on the chest X-ray consistent with the large opacity of complicated pneumoconiosis and you have the proper history, then it is reasonable to make a diagnosis of complicated pneumoconiosis because of the large opacity." (DX 44, p. 24) Dr. Fino noted that the miner's chest X-rays showed opacities in the apices of the lungs, which he considered to be "classic" signs of tuberculosis. But Dr. Fino cautioned against any conclusion that the miner had tuberculosis since histoplasmosis, a fungal infection particularly common to where the miner resided, appears identical to tuberculosis on a chest X-ray. Dr. Fino noted that this infection, like tuberculosis, is asymptomatic. (DX 44. pp. 25 – 26) The physician considered several medical examinations of the miner, a review of the miner's coal mine employment history and cigarette-smoking history, and two pulmonary function studies. Based on all of this evidence, Dr. Fino concluded the miner had simple pneumoconiosis. (DX 44, p. 39)

[5] Judge Johnson also either omitted, or failed to discuss, what impact Dr. S. K. Paranthaman's medical opinion had on his conclusion. However, Judge Johnson concluded that the miner had complicated pneumoconiosis, and Dr. Paranthaman offered a similar opinion.

I find that this mischaracterization of Dr. Fino's medical opinion undermines Judge Johnson's decision to give greater weight to the medical opinions which concluded that the miner had complicated pneumoconiosis. Judge Johnson did not consider Dr. Fino's diagnosis of simple pneumoconiosis nor did he explain how this diagnosis might have affected his decision. Additionally, Dr. Fino noted that tuberculosis is asymptomatic, which would explain why the miner might never have been treated for this disease in his lifetime. Dr. Fino's testimony calls into question Judge Johnson's determination to give less weight to the physicians who diagnosed tuberculosis based upon the rationale that there was "absolutely no clinical or historical support" for the disease.

Based on the foregoing, I find that Judge Johnson made a mistake in a determination of fact in his conclusion that the miner had complicated pneumoconiosis.

B. The Record as a Whole

I note that Employer has submitted additional medical opinions and chest X-ray interpretations by several of the physicians from the prior record. While the Board remanded this matter on several specific issues, in order to more accurately determine the nature of the miner's lung disease, I shall consider these additional opinions and chest X-ray interpretations in conjunction with the prior record and review the entire record *de novo*.

Chest X-ray evidence, § 718.202(a)(1)

The record contains the X-ray evidence set forth below.

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASS
9/25/74	--	DX 42	Dr. Rosenstein	B	2/0
4/3/89	4/3/89	DX 14	Dr. Navani	BCR, B	1/2 p/q, B
4/3/89	9/25/90	DX 37	Dr. Capiello	BCR, B	2/1 q/p, A
4/3/89	9/18/90	DX 37	Dr. Aycoth	BCR, B	2/2, q/r, A
4/3/89	5/7/90	DX 38	Dr. Dahhan	B	0/1, q/t
4/3/89	6/26/90	DX 39	Dr. Wheeler	B, BCR	0/1, r/t
4/3/89	6/26/90	DX 39	Dr. Scott	BCR, B	0/1, r/t
4/3/89	7/23/90	DX 40	Dr. Templeton	BCR, B	0/1, q/s
4/3/89	8/8/90	DX 40	Dr. Fino	B	1/0
7/27/89	7/31/89	DX 20	Dr. Aycoth	BCR, B	2/3, r/q, A
7/27/89	7/28/89	DX 42	Dr. Capiello	BCR, B	1/2, q/p

7/27/89	10/27/89	DX 30	Dr. Templeton	BCR, B	0/1, q/s
7/27/89	10/27/89	DX 30	Dr. Scott	BCR, B	0/1, s/r
7/27/89	10/27/89	DX 30	Dr. Wheeler	BCR, B	0/1, q/s
7/27/89	5/7/90	DX 38	Dr. Dahhan	BCR, B	0/1, q/r
7/27/89	8/8/90	DX 40	Dr. Fino	B	1/0
8/8/90	8/8/90	DX 40	Dr. Fino	B	1/0
8/8/90	10/2/90	DX 41	Dr. Dahhan	B	0/1, q/t
8/8/90	10/17/90	DX 41	Dr. Templeton	BCR, B	0/1, q/s
8/8/90	9/21/90	DX 41	Dr. Scott	BCR, B	1/1, p/s
8/8/90	9/21/90	DX 42	Dr. Wheeler	BCR, B	1/2, q/s
--	2/16/01	EX 1, 8	Dr. Fino	B	Unreadable
4/30/92	2/16/01	EX 1, 8	Dr. Fino	B	Unreadable
4/30/92	5/18/01	EX 3, 4	Dr. Scott	BCR, B	0/0
4/30/92	5/19/01	EX 3, 4	Dr. Wheeler	BCR, B	0/0
4/30/92	6/15/01	EX 2, 4	Dr. Castle	B	1/2
11/11/93	2/16/01	EX 1, 8	Dr. Fino	B	Unreadable
11/11/93	5/18/01	EX 3, 4	Dr. Scott	BCR, B	0/0
11/11/93	5/19/01	EX 3, 4	Dr. Wheeler	BCR, B	0/0
11/11/93	6/15/01	EX 2, 4	Dr. Castle	B	1/2
4/16/00	2/16/01	EX 1, 8	Dr. Fino	B	Unreadable
4/17/00	5/19/01	EX 3, 4	Dr. Wheeler	BCR, B	0/0
4/17/00	6/15/01	EX 2, 4	Dr. Castle	B	Unreadable
4/18/00	5/19/01	EX 3, 4	Dr. Wheeler	BCR, B	0/0
4/18/00	6/15/01	EX 2, 4	Dr. Castle	B	Unreadable

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983); Sharpless v. Califano, 585 F.2d 664, 666-7 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given

more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co. 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The September 25, 1974 chest X-ray was interpreted as positive by a qualified physician. Consequently, I find that this chest X-ray is positive for the presence of pneumoconiosis.

The April 3, 1989 chest X-ray was interpreted as negative for the presence of pneumoconiosis by four physicians who are B-readers. Four physicians who are B-readers interpreted the chest X-ray as positive for the presence of pneumoconiosis and three of these physicians considered the chest X-ray to show signs of complicated pneumoconiosis. As the film was considered to be both positive and negative by an equal number of qualified physicians, I find that the interpretations are in equipoise. Consequently, this chest X-ray can be considered neither positive nor negative for the presence of pneumoconiosis.

The July 27, 1989 chest X-ray was interpreted as negative for the presence of pneumoconiosis by four physicians who are B-readers. Three physicians who are B-readers interpreted the chest X-ray as positive for the presence of pneumoconiosis, one of whom considered the chest X-ray to show signs of complicated pneumoconiosis. As more B-readers considered the film to be negative, I find that this chest X-ray is negative for the presence of pneumoconiosis.

The August 8, 1990 chest X-ray was interpreted as negative for the presence of pneumoconiosis by two physicians who are B-readers. Three physicians who are B-readers interpreted the chest X-ray as positive for the presence of pneumoconiosis. As more B-readers considered the film to be positive, I find that this chest X-ray is positive for the presence of pneumoconiosis.

A chest X-ray of an undeterminable date was reviewed by Dr. Fino on February 16, 2001 and considered to be unreadable. Consequently, this chest X-ray can be considered neither positive nor negative for the presence of pneumoconiosis.

The April 30, 1992 chest X-ray was interpreted as negative for the presence of pneumoconiosis by two physicians who are B-readers. One physician who is a B-reader interpreted the chest X-ray as positive for the presence of pneumoconiosis and another B-reader considered the film to be unreadable. As more B-readers considered the film to be negative than positive, I find that this chest X-ray is negative for the presence of pneumoconiosis.

The November 11, 1993 chest X-ray was interpreted as negative for the presence of pneumoconiosis by two physicians who are B-readers. One physician who is a B-reader interpreted the chest X-ray as positive for the presence of pneumoconiosis and another B-reader considered the film to be unreadable. As more B-readers considered the film to be negative than positive, I find that this chest X-ray is negative for the presence of pneumoconiosis.

The April 16, 2000 chest X-ray was reviewed by Dr. Fino on February 16, 2001 and determined to be unreadable. Consequently, this chest X-ray can be considered neither positive nor negative for the presence of pneumoconiosis.

The April 17, 2000 chest X-ray was interpreted as negative for the presence of pneumoconiosis by a B-reader. Another B-reader considered the film to be unreadable. As the opinions regarding whether the film is unreadable are in balance, I find that Claimant has not established that it is readable. Therefore, the film is neither positive nor negative for the presence of pneumoconiosis.

The April 18, 2000 chest X-ray was interpreted as negative for the presence of pneumoconiosis by a B-reader. Another B-reader considered the film to be unreadable. As the opinions regarding whether the film is unreadable are in balance, I find that Claimant has not established that it is readable. Therefore, the film is neither positive nor negative for the presence of pneumoconiosis.

In sum, I find that the September 25, 1974 chest X-ray and August 8, 1990 chest X-ray are positive for the presence of pneumoconiosis. I also find that the July 27, 1989, April 30, 1992, and November 11, 1993 chest X-rays are negative for the presence of pneumoconiosis. Based on the greater number of X-rays that are negative for the presence of pneumoconiosis, I find that the chest X-ray evidence is negative for the presence of pneumoconiosis.

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

Additionally, the physicians who interpreted the X-rays also explained their findings in medical opinions set forth in the record.

Dr. S. K. Paranthaman

In a report of an April 3, 1989 medical examination, Dr. S. K. Paranthaman[6] reported that he performed a medical examination of the miner and detected normal heart and lung function. The physician noted that the miner worked approximately 46 years in underground mining and smoked 20 cigarettes per day for approximately 10 years. The physician also apparently reviewed an interpretation of the April 3, 1989 chest X-ray that was interpreted positive for complicated pneumoconiosis. Dr. Paranthaman also reviewed the April 3, 1989 pulmonary function study and arterial blood gas study.

Dr. Paranthaman concluded that the miner had complicated pneumoconiosis due to coal dust exposure while working as a miner. The physician also opined that the miner was totally disabled. (DX 12)

Dr. Gregory J. Fino

In an October 4, 2001 deposition, Dr. Gregory J. Fino (Board certified in internal medicine and pulmonary disease) reiterated many of the findings from his prior reports, chest X-ray interpretations, and depositions. (EX 1; DX 44; DX 76) Dr. Fino stated that he performed a medical examination of the miner during his lifetime and reviewed the April 30, 1992 and November 11, 1993 chest X-ray films. Dr. Fino considered these chest X-rays to be positive for the presence of simple pneumoconiosis with a 1/1 profusion. The physician reviewed the April 17, 2000 and April 18, 2000 chest X-ray films and opined that these two films were unreadable. Dr. Fino did not detect evidence of emphysema around the lesions he observed on the chest X-ray films. According to Dr. Fino, the presence of emphysema would be expected in a case of complicated pneumoconiosis. (EX 8, pp. 6 – 11)

Dr. Fino stated that another acceptable diagnosis would be some form of granulomatous disease. The physician stated that the chest X-rays "could be" interpreted as tuberculosis based on the fibronodular stranding he observed.[7] Dr. Fino also detected fibronodular stranding on a CT scan of the miner's lungs and stated that pneumoconiosis is more often indicated by the appearance of egg shell calcification and nodular changes. However, based on the miner's coal mine employment history, lack of medical treatment for tuberculosis, and no positive test results for tuberculosis, he diagnosed the miner with simple pneumoconiosis. (EX 8, pp. 12 – 14) Dr. Fino also stated that he agreed with Dr. Wheeler that tuberculosis was a "possibility," however

> having read the records and having examined this man and having information over an 11 year period of time, seeing the clinical stuff that a radiologist would not see, I can tell Dr. Wheeler that this man does not have tuberculosis. But just looking at an X-ray as an

[6] Dr. Paranthaman's qualifications are not of record.

[7] Fibronodular stranding is a long scarring or lines inside the lungs connecting various areas of lung nodules.

> isolated picture of his lungs, tuberculosis would certainly be a potential differential diagnostic possibility.

(EX 8, p. 46)

Dr. Fino performed a medical examination of the miner during his lifetime and detected abnormal breathing patterns. Dr. Fino opined that the miner's pulmonary condition would not have prevented him from working. Dr. Fino also stated that the miner died due to an abdominal aortic aneurysm and not a pulmonary event. Dr. Fino described an abdominal aortic aneurysm as a rupturing of the aortic artery leading to the stomach, which he characterized as a "catastrophic event." The physician based this conclusion upon his review of a preoperative diagnosis of the miner, the miner's death certificate, and a pathology report. (EX 8, pp.15 – 21)

Dr. William W. Scott, Jr.

In a May 18, 2001 review of the November 11, 1993 chest X-ray and a May 18, 2001 review of the April 30, 1992 chest x-ray, Dr. William W. Scott (Board-certified in radiology) opined that these x-rays were negative for the presence of pneumoconiosis. Additionally, the physician detected scarring and masses which he noted to be "most likely" or "probably" due to tuberculosis. (EX 3).

Dr. Joseph J. Renn

In a December 17, 2000 medical report, Dr. Joseph J. Renn (Board-certified in internal medicine and pulmonary disease) stated that he reviewed the 22 interpretations of the chest X-rays dated September 25, 1974, April 3, 1989, July 27, 1989, and August 8, 1990. Dr. Renn noted that the miner worked in coal mining for 43 years. The physician reported that the miner smoked one pack of cigarettes per day from approximately 1966 until 1976 but also reported smoking, "off and on for ten years at the rate of one package of cigarettes daily between 1942 and 1974." (DX 75) Dr. Renn reviewed both pulmonary function studies and arterial blood gas studies of record and reports of medical examinations by Dr. S. K. Paranthaman and Dr. Fino.

Based on the foregoing, Dr. Renn concluded that,

> there is equal division among the interpreting physicians regarding the presence or absence of simple pneumoconiosis. The overwhelming majority feel there is no evidence for complicated pneumoconiosis. Without having the opportunity to review the actual chest radiographs myself the dilemma cannot be further resolved.

(DX 75) In spite of above statement, Dr. Renn concluded that the miner had simple pneumoconiosis. Dr. Renn also opined that the miner was not totally disabled. (DX 75)

Dr. Paul S. Wheeler

In an August 20, 2001 deposition, Dr. Paul S. Wheeler (Board certified in radiology) reiterated his findings from his review of the chest X-rays performed on April 3, 1989, July 27, 1989, August 8, 1990, April 30, 1992, November 11, 1993, April 17, 2000, and April 18, 2000. (EX 3; 4) Dr. Wheeler stated that the April 3, 1989 and July 27, 1989 chest X-rays were negative for the presence of pneumoconiosis but showed fibrosis consistent with tuberculosis. Dr. Wheeler opined that the August 8, 1990 chest X-ray showed evidence of pneumoconiosis with a 1/2 profusion and evidence of possible healed tuberculosis. The physician reviewed the April 30, 1992 chest X-ray and stated that this film showed evidence of "calcified granulomata" consistent with tuberculosis. Additionally, Dr. Wheeler noted that this calcified granulomata was outside of the lung zone where pneumoconiosis would be expected to appear. Dr. Wheeler reviewed the November 11, 1993 chest X-ray and stated that the film showed evidence of infiltrates of fibrosis which were outside of the "strike zone" where pneumoconiosis might be expected to appear. Finally, Dr. Wheeler reviewed the April 17, 2000 and April 18, 2000 chest X-rays and opined that these films showed evidence of scarring due to tuberculosis. (EX 6, pp. 24 – 33)

Based on the chest X-ray films he reviewed, Dr. Wheeler concluded that the miner had tuberculosis that self-cured and left scars. Dr. Wheeler opined that the miner did not have pneumoconiosis. Dr. Wheeler stated that pneumoconiosis is not progressive, but instead stabilizes over time while a majority of "granulomatous" diseases (such as tuberculosis) self-cure over time. Upon cross-examination, Dr. Wheeler admitted that he opined that the August 8, 1990 chest X-ray showed evidence of pneumoconiosis, profusion 1/2. Dr. Wheeler also stated that the August 8, 1990 chest X-ray showed evidence of healed tuberculosis and that later chest X-rays showed evidence of a mass which he attributed to a possible reoccurance of tuberculosis. However, Dr. Wheeler stated that he reviewed no other medical records of the miner nor was he aware that the miner was never treated for tuberculosis by his family physician. (EX 6, pp. 36 – 55)

Dr. James R. Castle

In an August 7, 2001 deposition, Dr. James R. Castle (Board-certified in internal medicine and pulmonary disease) reiterated many of the conclusions for his June 20, 2001 medical report. (EX 2, 4) Dr. Castle reviewed the April 30, 1992 chest X-ray film and the November 11, 1993 chest X-ray film and considered these films to show evidence of pneumoconiosis, 1/2 profusion, and a granulomatous disease which he considered to be tuberculosis. Dr. Castle stated that this granulomatous disease appeared in the apex of the miner's lungs, which he considered to be outside the lung area where pneumoconiosis would be expected to appear. Dr. Castle also considered the miner's approximately 38 years of coal mine employment and a 1990 report of a CT scan by Dr. Imperiale. Dr. Castle stated that the 1990 CT scan reported showed "changes in mediastinal nodes," which Dr. Castle considered to be a sign of a granulomatous process. (EX 5, pp. 17 – 26)

Based on the foregoing evidence, Dr. Castle concluded that the miner had simple pneumoconiosis and tuberculosis. Dr. Castle also noted that while the miner may never have

been treated for tuberculosis, the physician stated that tuberculosis is usually self-healing and may not require any treatment. Dr. Castle did not personally review any chest X-ray films that were considered to show the presence of complicated pneumoconiosis. Additionally he did not consider the miner's testimony before Judge Johnson, nor did he review Judge Johnson's 1993 benefits award based on a finding of complicated pneumoconiosis. (EX 5, pp. 17 – 26)

Dr. Castle further opined that the miner was not totally disabled due to pneumoconiosis. The physician considered the results of pulmonary function studies and noted only a moderate obstruction. Additionally, Dr. Castle stated that the miner was being treated for problems related to hypertension, as opposed to pneumoconiosis, prior to his death. However, the physician admitted that the miner was not treated for hypertension after 1988. Dr. Castle opined that the miner could have returned to his prior coal mine employment, but not heavy manual labor. (EX 5, pp. 26 – 45)

Regarding the cause of the miner's death, Dr. Castle reviewed the miner's death certificate and stated that the miner died as a result of hypovolemic shock caused by a ruptured abdominal aortic aneurysm. Dr. Castle considered this to be the result of artereosclerotic heart disease which, over time, ruptured the miner's aorta. The physician stated that pneumoconiosis was not the cause of the miner's death. (EX 5, pp. 29 – 34)

I find Dr. Fino's medical opinion that the miner had simple pneumoconiosis to be reasoned and well-documented. An opinion is well-documented and reasoned when it is based on evidence such as physical examinations, symptoms, and other adequate data that support the physician's conclusions. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A medical opinion that is undocumented or unreasoned may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989); see also Duke v. Director, OWCP, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis). Here, Dr. Fino relied upon physical examinations of the miner in addition to reviewing several chest X-rays, pulmonary function studies, arterial blood gas studies, and considering the miner's extensive coal mine employment history. I also note that Dr. Fino is well-qualified to render such an opinion.

Additionally, I note that at the heart of Judge Johnson's 1994 benefits award was his decision to credit the complicated pneumoconiosis medical opinions over the simple pneumoconiosis/tuberculosis medical opinions. For the reasons that follow, I find that Dr. Fino's medical opinion resolves the dispute over whether the miner had tuberculosis or whether the miner had some degree of pneumoconiosis.

Dr. Fino noted in his 2001 deposition that the miner was never treated or tested for tuberculosis in his lifetime. Dr. Fino also explained how radiologists could mistake the markings inside the miner's lungs as consistent with tuberculosis or complicated pneumoconiosis. According to Dr. Fino, "just looking at an X-ray as an isolated picture of his lungs, tuberculosis would certainly be a potential differential diagnostic possibility." (EX 8, p. 46) In order to better determine the nature of the the miner's lung disease, Dr. Fino considered the miner's coal mine employment history and performed physical examinations of the miner. Dr. Fino also

considered pulmonary function studies and read the results of two CT scans dated September 24, 1990 and October 1, 1990. Considering the entirety of this evidence, Dr. Fino opined that the miner had simple pneumoconiosis and not tuberculosis or complicated pneumoconiosis.

I find that Dr. Castle's opinion that the miner had simple pneumoconiosis and tuberculosis must be given less weight than Dr. Fino's medical opinion that the miner only had simple pneumoconiosis. While Dr. Castle considered several chest X-rays and CT scans to show signs of scarring commonly found with tuberculosis, I note that Dr. Fino indicated that relying on chest X-ray readings and CT scans was not totally accurate since tuberculosis and pneumoconiosis markings are similar. Additionally, Dr. Fino noted that the miner was never tested or treated for tuberculosis in his lifetime. While Dr. Castle stated that tuberculosis is often self-healing and most people never treat for the disease, Dr. Fino stated that another lung disease, histoplasmosis, may appear identical to tuberculosis on a chest X-ray and also be asymptomatic. (DX 44, pp. 25 – 26) Finally, I note that Dr. Castle did not personally review any of the chest X-ray films that were considered to show the presence of complicated pneumoconiosis. Considering the miner's extensive coal mine employment history, I find that Dr. Fino's medical opinion that the miner had simple pneumoconiosis and not tuberculosis is entitled to more weight.

I find that Dr. Wheeler's medical opinion that the miner had tuberculosis must be given less weight than Dr. Fino's medical opinion. Dr. Wheeler reviewed the April 30, 1992, November 11, 1993, April 17, 2000, and April 18, 2000 chest X-rays and opined that the miner did not have pneumoconiosis. Dr. Wheeler considered these chest X-rays to show evidence of tuberculosis. However, Dr. Fino specifically addressed Dr. Wheeler's medical opinion during the October 4, 2001 deposition and discredited this tuberculosis theory. Dr. Fino stated that,

> having read the records and having examined this man and having information over an 11 year period of time, seeing the clinical stuff that a radiologist would not see, I can tell Dr. Wheeler that this man does not have tuberculosis. But just looking at an X-ray as an isolated picture of his lungs, tuberculosis would certainly be a potential differential diagnostic possibility.

(EX 8, p. 46) Dr. Fino also noted that the miner had never received any treatment for tuberculosis nor received any positive test results that indicated the presence of tuberculosis. Finally, based on the superior qualifications of Dr. Fino, I find that his opinion is entitled to more weight than Dr. Wheeler's medical opinion.

I find that Dr. Scott's medical opinion and Dr. Renn's medical opinion must be given less weight than Dr. Fino's medical opinion. A medical opinion that is unclear or equivocal is entitled to little or no weight. Justice v. Island Creek Coal Co., 11 B.L.R. 1-91 (1988); Parsons v. Black Diamond Coal Co., 7 B.L.R. 1-236 (1984). Here, Dr. Scott opined that scarring he observed on the miner's chest X-ray was "most likely" or "probably" due to tuberculosis. As Dr. Scott could not reach a definitive diagnosis regarding the miner's condition, I find that Dr. Scott's opinion is equivocal and entitled to less weight than Dr. Fino's medical opinion. Similarly, I note that Dr. Renn stated that he was unable to determine whether the miner had

simple pneumoconiosis or complicated pneumoconiosis since he did not have any chest X-ray films to review. However, he then concluded, without explanation, that the miner had simple pneumoconiosis. Consequently, I find that Dr. Renn's opinion is unclear and must be given less weight than Dr. Fino's medical opinion.

Based on the foregoing, I find that the medical opinion evidence as a whole supports a finding that the miner had simple pneumoconiosis rather than complicated pneumoconiosis. Further, the four X-ray interpretations of complicated pneumoconiosis are not only contradicted by the other interpretations of the April 3, 1989 and July 27, 1989 films, they are also heavily outweighed by the 13 contrary interpretations of the later films. I therefore find that Claimant has failed to establish the presence of complicated pneumoconiosis.

As previously noted, the chest X-ray evidence does not support a finding of simple pneumoconiosis. However, I give the chest X-ray evidence less weight than the medical opinion evidence for the following reasons.

First, I note that the September 25, 1974 and August 8, 1990 chest X-rays both support a finding of simple pneumoconiosis. However, subsequent chest X-ray examinations performed on July 27, 1989, April 30, 1992, and November 11, 1993 each support a finding of no pneumoconiosis. In resolving a conflict between later chest X-rays that show the miner's condition somehow improved, I note that the Fourth Circuit has held that

> *[i]t is impossible to reconcile the evidence*. Either the earlier or the later result *must* be wrong, and it is just as likely that the later evidence is faulty as the earlier. The reliability of irreconcilable items of evidence must therefore be evaluated without reference to their chronological relationship.

Adkins v. Director, OWCP, 958 F.2d 49, 52 (1992). In order to reconcile these chest X-ray interpretations, I find that it is proper to give more weight to the medical opinions. Specifically, the medical opinion of Dr. Fino (to which I give greater weight than the opinions of Dr. Castle, Dr. Wheeler, Dr. Paranthaman, Dr. Renn, and Dr. Scott) is based upon pulmonary function studies, and reviews of the miner's medical, cigarette-smoking, and coal mine employment histories. Dr. Fino stated that chest X-ray interpretations were not as accurate as this other objective medical information since tuberculosis, histoplasmosis, and pneumoconiosis are often indistinguishable on chest X-ray films.

Employer has also submitted records of the miner's treatment at Mercy Hospital from September 24, 1990 through April 17, 2000. (DX 79) For the following reasons, I find that the treatment records are entitled to less weight than the medical opinion of Dr. Fino. The treatment records contain two CT scans of the miner's chest performed on September 24, 1990 and October 1, 1990. Dr. Salvatore Imperiale interpreted both CT scans as "possibly" showing evidence of granulomatous disease but recommended further CT scans and chest X-rays to confirm this diagnosis. I find that Dr. Imperiale was unable to reach a definitive conclusion regarding the miner's condition and I accordingly give his opinion less weight than the opinion of Dr. Fino. The treatment records also contain several notes of chest X-ray interpretations

which are not classified according to the method set forth in § 718.102(b). Accordingly, I give no weight to these chest X-ray notes. The remainder of the treatment records contains the notes of Dr. P. B. Kapadia. These notes are mostly illegible and appear to document routine office check-ups. Because these notes are unclear and do not address whether the miner had pneumoconiosis, I give these notes no weight.

For the foregoing reasons, I find that the medical opinion evidence is entitled to greater weight than the chest X-ray evidence. Consequently, I find that the record evidence establishes that the miner had simple pneumoconiosis.

2. Pneumoconiosis Arising Out of Coal Mine Employment

In order to establish entitlement to survivor's benefits, Claimant must also show that the miner's pneumoconiosis arose out of coal mine employment. The regulations provide that, "[i]f a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment." § 718.203(b) However, where a miner has established less than ten years of coal mine employment history, "it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship." § 718.203(c).

Employer has stipulated that the miner worked in coal mine employment for 39 years, entitling Claimant to the benefit of the rebuttable presumption that the miner's pneumoconiosis arose out of coal mine employment. Employer has not presented any evidence rebutting this presumption. Consequently, I find that Claimant has established this element of entitlement.

3. Total Disability

Claimant must establish that the miner is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner
>
> (i) From performing his or her usual coal mine work; and
> (ii) From engaging in gainful employment . . . in a mine or mines . . .

§ 718.204(b)(1).

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a); see also, Beatty v. Danri Corp., 16 B.L.R. 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993 (3d Cir. 1995).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. § 718.204(b)(2)(i-iv). Producing evidence under one of these four ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of pulmonary function study results is dependent on Claimant's height, which was noted to be approximately 69 inches. I therefore used that height in evaluating the studies. Protopappas v. Director, OWCP, 6 B.L.R. 1-221 (1983).

The current record contains the pulmonary function studies summarized below.

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1/FVC	EFFORT	QUALIFIES
4/3/89	DX 10	Dr. Paranthaman	65	1.80	3.90	90	--	Good	No
8/8/90	DX 40	Dr. Fino	66	1.98 2.16*	3.92 4.27*	62 78*	51 51*	-- --*	No No*

*post-bronchodilator

April 3, 1989 Pulmonary Function Study

This study produced nonqualifying values under the regulations. § 718.204(b)(2)(i). In a review of this study on June 22, 1989, Dr. Bernard P. McQuillen[8] opined that this study was acceptable. (DX 11)

August 8, 1990 Pulmonary Function Study

This study produced values that were nonqualifying under the regulations. § 718.204(b)(2)(i).

Based on the foregoing, I find that the weight of the pulmonary function study evidence does not support a finding of total disability pursuant to § 718.204(b)(2)(i).

The current record contains the arterial blood gas studies summarized below.

[8] Dr. McQuillan is not board-certified in a relevant field of medicine.

DATE	EX. NO.	PHYSICIAN	PCO2	PO2	QUALIFIES
4/3/89	DX 13	Dr. Paranthaman	42 44*	73 60*	No Yes*
8/8/90	DX 40	Dr. Fino	40 42*	77 71*	No No*

*post-exercise

The April 3, 1989 blood gas study produced a qualifying value post-exercise. However, the August 8, 1990 blood gas study did not produce any qualifying results. Consequently, I find that these studies are in equipoise. Based on the foregoing, Claimant has not established total disability under the provisions of § 718.204(b)(2)(ii).

Under § 718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv).

Of the physicians who discussed disability, only Dr. Paranthaman considered the miner to be totally disabled. Dr. Fino, Dr. Renn, and Dr. Castle each opined that the miner was not totally disabled. Dr. Paranthaman, Dr. Fino, Dr. Renn, and Dr. Castle each based their opinions upon reviews of pulmonary function tests and arterial blood gas studies. While I find that all of these opinions are reasoned and well-documented, I give less weight to Dr. Paranthaman's medical opinion based on the superior credentials of Dr. Fino, Dr. Renn, and Dr. Castle.

As previously stated, the pulmonary function tests and arterial blood gas studies do not support a finding of total disability. The medical opinion evidence does not support a finding of total disability. Consequently, I find that Claimant has not proven that the miner was totally disabled pursuant to § 718.204(b)(2)(i) – (iv).

3. Total Disability Due to Pneumoconiosis

As Claimant has not established that the miner was totally disabled, there is no need to address this causation issue.

4. Death Due to Pneumoconiosis

As this survivor's claim was filed after January 1, 1982, under § 718.1 Claimant must show that the miner's death was due to pneumoconiosis. Death due to pneumoconiosis may be established under § 718.205(c) by any one of the following criteria:

1. Competent medical evidence establishes that pneumoconiosis was the cause of the miner's death.

2. Evidence that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or that death was caused by complications of pneumoconiosis.

3. Under § 718.304, the miner suffered from a chronic dust disease of the lung and chest X-ray evidence shows one or more large opacities (greater than 1 centimeter), biopsy or autopsy shows massive lesions in the lung, or other evidence (in accord with acceptable medical procedures) show a condition which could reasonably be expected to yield such large opacities or massive lesions.

Section 718.205(c)(5) provides that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5).

As noted above, the record does not support any findings of large opacities, massive legions, or any other condition which a physician has stated could be expected to result in these. Therefore, § 718.304 is inapplicable here.

Further, no physician of record opined that pneumoconiosis contributed to the miner's death in any way. Dr. Fino and Dr. Castle both opined that the miner died due to massive blood loss as a result of a ruptured abdominal aorta.

Dr. Castle stated that artereosclerotic heart disease often causes fatty deposits to build up inside the aorta, causing the wall of the artery to weaken. According to Dr. Castle, the wall of the artery will eventually burst and patient often bleeds to death. (EX 5, pp. 29 – 34) Dr. Fino offered a similar opinion and described this condition as a "catastrophic event." (EX 8, pp. 15 – 21) Both physicians stated that pneumoconiosis did not contribute to the miner's death. In reaching their conclusions, both physicians reviewed the miner's medical treatment records from Mercy Hospital shortly before his death and the miner's death certificate.

I find that the opinions of Dr. Fino and Dr. Castle are both well-documented and reasoned. As previously noted, an opinion is well-documented and reasoned when it is based on evidence such as physical examinations, symptoms, and other adequate data that support the physician's conclusions. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A medical opinion that is undocumented or unreasoned may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989); see also Duke v. Director, OWCP, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis). In the instant matter, the miner's hospital records from Mercy Hospital document several hospital visits for a variety of reasons from September 24, 1990 through April 17, 2000. (DX 79) These records contain a report dated April 18, 2000 (the date of the miner's death) from Dr. James C. Steinmetz diagnosing the miner with a ruptured abdominal aortic aneurysm.

Additionally, I note that the miner's death certificate reports that the miner died due to hypovolemic shock and a ruptured aortic aneurysm. (DX 67) While a death certificate by itself is not sufficient to establish death due to pneumoconiosis, I note that the death certificate further supports Dr. Fino's and Dr. Castle's medical opinions that pneumoconiosis did not contribute to the miner's death. See Lango v. Director, OWCP, 104 F.3d 573 (3d Cir. 1997).

Based on the above, I find that Claimant has failed to establish that the miner's death was due to pneumoconiosis, pursuant to § 718.205(c).

C. Conclusion

I find that the miner had simple pneumoconiosis (not complicated pneumoconiosis) and that Employer has established a mistake of fact pursuant to § 725.310. I also find that Claimant has not established that the miner was totally disabled due to pneumoconiosis or that pneumoconiosis contributed to the miner's death.

Consequently, both the living miner's claim and the survivor's claim must be denied.

ATTORNEY FEE

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

Employer's request for modification of denial of the living miner's claim is AFFIRMED.

The living miner's claim of William A. Sharpe and the survivor's claim of Mae Ann Sharpe for benefits under the Act are DENIED.

A

Robert D. Kaplan
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.